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DATE NOTICE SENT TO ALL PARTIES: Apr/01/2016

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: Left shoulder surgery (SS) with subacromial decompression (SAD) with capsulotomy and manipulation under anesthesia (MUA)

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: MD, Board Certified Orthopedic Surgery

REVIEW OUTCOME: Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:
[X] Upheld (Agree)
[ ] Overturned (Disagree)
[ ] Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether medical necessity exists for <u>each</u> health care service in dispute. It is the opinion of this reviewer that the request for left shoulder surgery (SS) with subacromial decompression (SAD) with capsulotomy and manipulation under anesthesia (MUA) is not medically necessary

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male with complaints of shoulder pain. On XX/XX/XX, an MR arthrogram of the left shoulder revealed minimal undersurface fibrillation of the subscapularis tendon, with edema, minimal fibrillation of the articular service of the mid supraspinatus at the bone tendon interface, a superior labral tear, mild acromioclavicular joint arthrosis with capsular hypertrophy, slight lateral downsloping of the acromion, mild bursitis, with no evidence of a high grade partial or full thickness rotator cuff tear with normal rotator cuff muscles. On XX/XX/XX, the patient was seen in clinic. He reported left shoulder pain with complaints of popping and limited range of motion, and patient was currently doing a home exercise program which was not helping him as much as physical therapy did. Left shoulder exam revealed tenderness at the acromion, and bicipital groove and deltoid, and range of motion was mildly decreased. Shoulder strength was mildly decreased. There was a positive Neer's and Hawkin's sign, a positive empty can test, positive cross body compression test, and a left shoulder capsulotomy with manipulation under anesthesia was discussed.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: On XX/XX/XX, a utilization review letter was submitted noting the requested surgery was non-certified, referencing Official Disability Guidelines shoulder chapter, and noting there was no documentation of significant restricted range of motion with abduction less than 90 degrees to warrant the use of manipulation and anesthesia.

On XX/XX/XX, a utilization review report noted the request was not certified for a left shoulder surgery, subacromial decompression, capsulotomy and manipulation under anesthesia, and Official Disability Guidelines shoulder chapter was utilized. It was noted that range of motion measurements were not provided in the records, and guidelines recommend manipulation only after three to six months of conservative care where abduction remains less than 90 degrees. Therefore the request was non-certified.

The submitted records for this review include the clinical note of XX/XX/XX, where range of motion was mildly decreased. There was no indication of abduction of less than 90 degrees.

It is the opinion of this reviewer that the request for left shoulder surgery (SS) with subacromial decompression (SAD) with capsulotomy and manipulation under anesthesia (MUA) is not medically necessary and prior denials are upheld.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

[ ] ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

[ ] AHCPR-AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

[ ] DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

[ ] EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

[ ] INTERQUAL CRITERIA

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

[ ] PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

[ ] TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

[ ] TEXAS TACADA GUIDELINES

[ ] TMF SCREENING CRITERIA MANUAL

[ ] PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

[ ] OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)